THIRD PARTY LIABILITY

The Nevada Medicaid program is designed to function primarily as a cost avoidance system. This method was chosen as the most efficient and least costly due to the multitude of insurance companies utilized by Nevada residents. Also, insurance data is fed into our bill paying system on an individual basis through our local Welfare district offices. Direct contact is made by the Eligibility Certification Specialist (ECS) with the policy holder or dependent and all available information is collected.

However, when necessary, post-payment recovery is also incorporated.

Criteria have therefore been established for both systems with emphasis on cost effectiveness and FFP compliance.

I. Cost Avoidance - Medical Insurance/Established Casualty Policy

A. Claims with Medicaid paid amounts greater than zero are rejected on the remittance advice with insurance billing instructions and carrier information.

B. Services identified by individual policies as non-covered are not subject to cost avoidance or recovery.

II. Post-Payment Recovery - Medical Insurance

A. Recovery From Provider

1. Claims which were unidentified or missed in cost avoidance are subject to A above. Recovery is made by computer history adjustments.

2. Recovery efforts are not attempted when more than 12 months have elapsed from date of service to the projected adjustment date. (Insurance company filing dates rarely exceed this time limit. Also, it becomes increasingly difficult for providers to locate policy holders.)

B. Direct Post-Payment Recovery - Insurance Carrier

1. When necessary, direct recovery is attempted through individual insurance carriers. This can occur when providers are unsuccessful with billing attempts, but the fiscal agent (FA) has sufficient information to pursue collection. Claims with Medicaid paid amounts of less than $25 are not pursued.

2. Claims with Medicaid paid amounts of $25 or greater are pursued by the FA through the individual insurance company.

III. Post-Payment Recovery - Casualty Subrogation Process

A. Claims which edit for trauma codes are processed through the regular processing cycle. If the billed amount is $125 or greater and no insurance has paid on the claim, the claim is referred to the FA subrogation section for follow-up.

B. If the billed amount is less than $125, no investigation is initiated unless numerous claims exist for this diagnosis or service date.

C. Claims with billed amounts of $125 or more are investigated and followed through the legal process until settlements are reached or a determination made to drop the case.